WILLOW SAGE SERVICES

211 S Woodruff Ste. A-3 Idaho Falls ID 83401 Phone: 208-524-4818 Fax: 208-522-6630
440 E. Clark Street Ste. A Pocatello ID 83201 Phone: 208-233-1276 Fax: 208-233-0835

Willow Sage Services
Behavioral Health Clinic

"There is no Health without Mental Health"

NEW CLIENT INTAKE PACKET

(PLEASE PRINT LEGIBLY)

CLIENT CONTACT INFORMATION *(The following items apply to the CLIENT, not to the parent/guardian)*

TODAY'S DATE	
CLIENT'S FULL LEGAL NAME	
CLIENT'S DATE OF BIRTH	/ / **SOCIAL SECURITY NUMBER:**
ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	**HOME PHONE:** **MOBILE PHONE:**
EMAIL ADDRESS	
PREFERRED COMMUNICATION	[__] HOME PHONE [__] MOBILE PHONE [__] Email [__] TEXT MSG
OK TO LEAVE VOICE MESSAGE	[__] HOME PHONE [__] MOBILE PHONE
CLIENT LANGUAGE	**PARENTS LANGUAGE:**
HOW DID YOU HEAR ABOUT US?	

CLIENT DEMOGRAPHICS *(The following items apply to the CLIENT, not to the parent/guardian)*

ADMISSION STATUS:	[___] VOLUNTARY [___] COURT ORDERED [___] MALE [___] FEMALE [___] OTHER
MARITAL STATUS (CLIENT)	[___] Married [___] Divorced [___] Separated [___] Never Married [___] Other
SCHOOL:	**GRADE**:
NOTE: *We will need copies of: IEP or "504 Plan," School Psychological report, Positive Behavioral Support Plan, etc.*	
CLIENT'S EMPLOYER	
CLIENT'S EMPLOYER'S ADDRESS	**PHONE**:
CLIENT'S ETHNICITY / NATIONAL ORIGIN	[___] Caucasian (White) [___] African American [___] Native American(Tribal) [___] Asian [___] Hispanic/Latino [___] Other:
CLIENT'S RELIGIOUS / SPIRITUAL PREFERENCE	

EMERGENCY / GUARDIAN INFORMATION

EMERGENCY CONTACT	**PHONE**:
PARENT / GUARDIAN NAME	
PARENT / GUARDIAN DOB	/ / **PARENT / GUARDIAN SS #**:
PARENTS' MARITAL STATUS	[___] Married [___] Divorced [___] Separated [___] Never Married [___] Other
NONCUSTODIAL PARENT	
MAILING ADDRESS	**PHONE:**
To provide services to children or adults with guardians, we must have current copies of custody orders, parenting plans, orders of protection, guardianship orders, powers of attorney or other documents bearing on legal custody, decision-making, etc.	

INSURANCE INFORMATION *(Copies of insurance cards and Photo ID are required)*

Primary Insurance		**Secondary Insurance**	
Company Name		**Company Name**	
Policy Number		**Policy Number**	
Employer / Group		**Employer / Group**	
Insured Name		**Insured Name**	
Insured Date of Birth		**Insured Date of Birth**	
Relation to Client		**Relation to Client**	
Sliding Scale / Copay		**NOTE**: Medicaid is always considered secondary coverage	

CLIENTS BEHAVIORAL AND MEDICAL HEALTH INFORMATION

What is the Reason for requesting services? *(Provide a description of the **current** symptoms, problems, issues or events)*	_____ _____ _____
When did this begin, for how long and how often does this happen? *(Provide a description of* what and this started, the frequency and duration)when, impact)	_____ _____ _____
Impact: *(provide a description of how this impacts your life, relationships, school or work)*	_____ _____ _____
Family History: *(List any behavioral health conditions or treatment history in your family)*	_____ _____ _____
Current Medical/Health issues or problems: *(autoimmune, diabetes, blood pressure, heart, mobility etc.)*	_____ _____ _____
List all Known allergies: *(Food, medications or other allergies)*	_____ _____ _____
Family History: *(List any medical health conditions or treatment history in your family)*	_____ _____ _____

CLIENT'S CURRENT BEHAVIORAL AND MEDICAL HEALTH CARE PROVIDERS

(Medicaid clients need a current history and physical done by their PCP annually)

Primary Care (MD, DO, NP, PA)	Name:	Phone:	Last Seen:
Other Medical Provider	Name:	Phone:	Last Seen:
Specialist:	Name:	Phone:	Last Seen:
Pharmacy	Name:	Phone:	Last Seen:
Psychiatrist (MD, DO, NP, PA)	Name:	Phone:	Last Seen:
Med.Manager (MD,DO,NP,PA))	Name:	Phone:	Last Seen:
Psychotherapist / Counselor:	Name:	Phone:	Last Seen:
CBRS Provide	Name:	Phone:	Last Seen:
Case Manager / TCC	Name:	Phone:	Last Seen:
Peer/Family Support	Name:	Phone:	Last Seen:
Target Service Coordinator:	Name:	Phone:	Last Seen:
Other DD Service Providers:	Name:	Phone:	Last Seen:

CLIENTS PREVIOUS BEHAVIORAL AND MEDICAL HEALTH CARE PROVIDERS

Primary Care (MD, DO, NP, PA)	Name:	Last Seen:	Outcome:
Other Medical Provider	Name:	Last Seen:	Outcome:
Specialist:	Name:	Last Seen:	Outcome:
Pharmacy	Name:	Last Seen:	Outcome:
Psychiatrist (MD, DO)	Name:	Last Seen:	Outcome:
Med.Manager (MD,DO,NP,PA))	Name:	Last Seen:	Outcome:
Psychotherapist / Counselor:	Name:	Last Seen:	Outcome:
CBRS Provide	Name:	Last Seen:	Outcome:
Case Manager / TCC	Name:	Last Seen:	Outcome:
Peer/Family Support	Name:	Last Seen:	Outcome:
Target Service Coordinator:	Name:	Last Seen:	Outcome:
Other DD Service Providers:	Name:	Last Seen:	Outcome:

CLIENTS CURRENT MEDICATIONS (It is recommend to have your pharmacy fax over your medication history)
Please take information directly from pill bottles. Include over-the-counter medications, supplements, vitamins, etc. :

Medication	Dose/Schedule	Purpose	Prescribed by

Client Questionnaire

SLEEP *(To be completed by or for all clients)*

What time do you usually go to bed?		What time do you usually get up?				
Insomnia – Do you (your child) have trouble with…	Falling asleep		Staying asleep		Early waking	
Waking up screaming or in a panic			YES		NO	
Waking up coughing			YES		NO	
Labored breathing or pauses in breathing during sleep			YES		NO	
Falling asleep during the day			YES		NO	
Strange noises during sleep			YES		NO	

Patient Health Questionnaire (PHQ-9) *(To be completed by or for all clients)*

Over the last <u>two weeks</u> has the patient been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed; or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
NOTE: If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? **Not difficult at all ____ Somewhat difficult ____Very difficult ___Extremely difficult ____**				

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) *(To be completed on intake by or for all clients)*

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. **For example**:		
--a serious accident or fire -- a physical or sexual assault or abuse -- an earthquake or flood --seeing someone be killed or seriously injured --a war --having a loved one die through homicide or suicide		
Have you ever experienced this kind of event?	**YES (Do next 5 items)**	**NO (SKIP NEXT SECTION)**
In the past month, have you… (Answer only if you responded "YES" above)		
Had nightmares about the events or thought about the event(s) when you did not want to?	YES	NO
Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
Been constantly on guard, watchful, or easily startled?	YES	NO
Felt numb or detached from people, activities	YES	NO
Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	YES	NO

asQ Suicide Risk Screening Tool (National Institute of Mental Health – NIMH) *(To be completed by or for all clients)*

1.	In the past few weeks, have you wished you were dead?	YES	NO
2.	In the past few weeks, have you felt that you or your family would be better off if you were dead?	YES	NO
3.	In the past week, have you been having thoughts about killing yourself?	YES	NO
4.	Have you ever tried to kill yourself?	YES	NO
5.	Are you having thoughts of killing yourself now?	YES	NO

Substance Use Screening Tool *(To be completed by or for all clients)*

The following questions concern information about your (or your child's) potential involvement with alcohol and other drugs during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Please answer every question. If you cannot decide, then choose the response that is mostly right.
When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used more than the directions and any non-medical use of drugs. "Drugs" may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed, meth), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, Oxycontin).

	Part A: During the PAST 12 MONTHS, did you?	**NO**	**YES**
1	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2	Smoke any marijuana or hashish?		
3	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
4	Have you ever used tobacco in any form (e.g., cigarettes, chew, cigars)?		
5	How often do you use tobacco in any form? [___] NEVER [___] OCCASIONALLY [___] DAILY		
	Part B: CRAFFT (Children and Teens)	**NO**	**YES**
1	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
3	Do you ever use alcohol or drugs while you are by yourself, or ALONE?		
4	Do you ever FORGET things you did while using alcohol or drugs?		
5	Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
6	Have you ever gotten into TROUBLE while you were using alcohol or drugs?		
	Part C: CAGE-AID (Adults)	**NO**	**YES**
C	Have you ever felt you ought to cut down on your drinking or drug use?		
A	Have people annoyed you by criticizing your drinking or drug use?		
G	Have you felt bad or guilty about your drinking or drug use?		
E	Have you ever had a drink or used drugs first thing in the morning to steady your nerves of to get rid of a hangover (eye-opener)?		

CHILDHOOD ANXIETY (Parents complete for children 12 and younger

Is your child more shy or anxious than other children her or his age?	NO	YES
Is your child more worried than other children her or his age?	NO	YES

Adverse Childhood Experiences Scale (ACES) *(To be completed by or for <u>all</u> clients, regardless of age)*

1	Did a parent or other adult in the household often or very often Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	YES	NO
2	Did a parent or other adult in the household often or very often Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	YES	NO
3	Did an adult or person at least 5 years older than you ever Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	YES	NO
4	Did you often or very often feel that No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	YES	NO
5	Did you often or very often feel that You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	YES	NO
6	Were your parents ever separated or divorced?	YES	NO
7	Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	YES	NO
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	YES	NO
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	YES	NO
10	Did a household member go to prison?	YES	NO

Treatment Goals Worksheet for Counseling

Client Name: _____ Date: _____

(To be completed by or for all clients)

INSTRUCTIONS: Please list your goals. (In clients' own words). These areas are listed only to suggest areas of concern. Number the goals in order of importance after all goals have been written.

Priority Number in order of importance	**Area**	**Issue:** Explain how you are struggling in this area	**Goals:** What/how do you want to improve in this area
3	Example: Social	I am so lonely. I have not one I can talk to because I don't have any friends that I can trust.	I just want one friend I can spend time with on the weekend.
1	Example: Family	I feel like all I do is fight with my family	I want my family to like me
2	Example: Vocational	I just lost my job. I keep getting fired for missing too many days at work.	I want to be able to support my family
	Vocational		
	Educational		
	Social Relationships		
	Family		
	Basic Living		
	Community		
	Legal		
	Housing		
	Financial		
	Health & Medical		

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INFORMED CONSENT & FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT FORM

I acknowledge that I have been offered a copy of these documents that I may ask at any time for a new copy of the CLIENT RIGHTS RESPONSIBILITY AND HIPAA. I have read and I understand the provided information. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost.

I understand that office personnel will provide reminders of appointments, in the form of SMS text messages or phone calls, but it is my responsibility to keep my appointments and to be on time. If I am unable to keep an appointment, I will contact the office or assigned worker as soon as possible.

FINANCIAL RESPONSIBILITY I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS I hereby authorize and direct payment of my medical benefits to (Willow Sage Services) on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE MEDICAL RECORDS I hereby authorize (Willow sage Services) to release private health information necessary to obtain payment to my insurer, governmental agencies, or any other entity financially responsible for my medical care.

In the event of an emergency and if I or the named emergency contact cannot be reached, I give my consent for the client to be treated as medically necessary and allow Willow Sage Services to release any information that may be necessary to aid in providing accurate and quality care.

CONSENT TO TREATMENT By signing this I give my informed consent for Willow Sage Services to provide the necessary treatment and services. I acknowledge that I have been offered education about prognosis and outcome as well as discussed the risks of not participating in treatment.

_____	_____	_____
Print FULL LEGAL Name of Client	Date of Birth	Social Security Number
_____	_____	_____
Print FULL LEGAL Name of Responsible Party	Date of Birth	Social Security Number

_____ _____

Signature of Client and or Responsible Party Date

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CLIENT RIGHTS, RESPONSIBILITIES, AND HIPAA

Willow Sage Services subscribes to an eclectic theoretical framework, which means we use a variety of approaches, based on the needs of the client and family. These include cognitive behavior therapy, Internal Family Systems therapy, Dialectical Behavior Therapy, Family Systems Therapy, Solution-Focused Therapy, Acceptance and Commitment Therapy, Hypnotherapy, EMDR (bilateral stimulation), and Behavior Therapy. We believe that each family and case is different and needs to be treated as such.

Client / Member Rights

The Right to receive information about services, providers, rights, and responsibilities. To be treated with respect and recognition of their dignity and right to privacy. To actively participate/involvement with providers in making decisions about their care. Provider disputes should not interfere with the professional relationship between the provider and them, to a candid discussion of appropriate or medically necessary treatment options for their condition. Be able to voice complaints or appeals about the services provided; make recommendations regarding the "Members' rights and responsibilities" policies. To receive care that is considerate and that respects their values and belief system. To personal privacy and confidentiality of information. To reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability. To individualized treatment, including adequate and humane services irrespective of the source(s) of financial support, the provision of services within the least restrictive environment possible, an individualized treatment or program plan, periodic review of the treatment or program plan, an adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan. To participate in consideration of ethical issues that may arise in providing care and services, including resolving conflict, withholding resuscitative services, foregoing or withdrawing life-sustaining treatment, participating in investigational studies or clinical trials. To designate a surrogate decision-maker if they are incapable of understanding a proposed treatment or procedure or cannot communicate their wishes regarding care. **To be informed**, along with their family, of their rights in a language they understand. To choose not to comply with recommended care, treatment, or procedures to be informed of the potential consequences of not complying with the treatment recommendations and to be informed of the possible consequences of not complying with the treatment recommendations. To be notified of rules and regulations concerning their conduct. To be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the decision. To be given information regarding their care options participation/involvement, medication education, and benefits and risks. The right to active involvement and participation in planning of care and services, that their participation is voluntary and is free to withdraw at any time, without giving a reason or cost. Encouragement and support will be provided for The Member and their families to engage and participate in making decisions about their health care options, identifying goals for treatment, and participating in assessments and evaluations will be documented.

To inspect and copy their protected health information (PHI) and also: request to amend their PHI, request an accounting of non-routine disclosures of PHI, request limitations on the use or disclosure of PHI, request confidential communications of PHI to be sent to an alternate address or by alternate means, make a complaint regarding use or disclosure of PHI, receive a Privacy Notice. Receive information about clinical guidelines, Quality Assurance, and Performance Improvement (QAPI) programs.

Accessibility to services, programs, and activities are available and accessible to all persons, including those with physical limitations, deaf, hard of hearing, blind, or other sensory impairments and persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standards. If we cannot accommodate a specific handicap accessible need, other arrangements will be made such as services in the home or an alternative setting or referral of members out if needed.

Access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability. Timely access to services and appointments. Routine within 10 business days. Urgent within 48 hours. No more than a 15 minute wait time for appointments. **Crisis services** are available to our members 24/7. Optum has a Crisis Line: (855) 202-0973. We have a crisis line available for Members to call after 5 pm on weekdays and weekends; the after hours contact number is 208-478-9551. During regular business hours, 8-5 pm Monday through Friday, the office number is 208-233-1276 or 208-524-4818. If they are unavailable, a message will state availability and a phone number of who a Member can call and emergency directions. Life threatening emergency 911 must be called immediately

If a client has a complaint or concern at any time, they may contact our office and request a "Grievance Form." and may fill this out and return it to our Executive or Clinical Director. If they are unable to fill out this report, the office assistant or another employee may assist. If they are uncomfortable with filing a "Grievance Form" with our office, for your protection and advocacy, you may contact the clinical director or the owner at 208-233-1276, or contact COAD at Boise: 208-336-5353 or Pocatello:208-232-0922. To file a complaint with the Department of Health and Welfare, use the table below to locate the correct contact information.

Client/Member Responsibilities

To provide information (to the extent possible) that is needed to provide you services and care. To Update your client information with in 3 days or as soon possible if you have a change in: your address, phone number, insurance information, name, primary care provider etc

It is your responsibility to **maintain your annual History and Physical** exam with your primary care provider and a release of information for coordination of care between providers. It is your responsibility to **self-report any medication, food or other substance allergies** immediately upon your knowledge to one of our staff members. We offer medication management, monitor medication and medication recalls. If you have been notified of a recall on a medication we have prescribed to you, please surrender it to the prescribing Doctor, Nurse Practitioner or PA immediately. It is your responsibility to **self-report infectious diseases** immediately upon your knowledge to one of our staff members. This will be reported to the local health authorities. *Providers will provide services to members based on a comfort level for both the member and the Provider. If an appropriate accommodation cannot be made a referral will be made to another provider.*

It is your responsibility to **keep scheduled appointments** and actively participate in treatment. Arrive 10 minutes prior to my scheduled appointment to begin the check-in process, which includes updating any changes to your demographics, providing copies of current insurance cards, etc. It is your responsibility to keep your appointments and to be on time. If you are unable to keep an appointment please contact your worker as soon as possible. If you are going to be out of town for a few days please let your worker know when you are leaving and when you will be back to reschedule your appointments. If you have any questions, please contact our office. For **cancellations or to reschedule** it is your responsibility to contact the office *at least 24 hours in advance* if unable to keep my scheduled appointment, or as soon as is practically possible in the event of an emergency. Failure to call in is documented as a **No Show** and may result in a $10.00 to $25.00 charge that you will be responsible to pay; due from me and not my insurance carrier. Willow Sage Services may discharge clients from care and terminate professional relationships if there are three (3) missed appointments without satisfactory cause or failure to contact the office in advance.

Court Testimony, Willow Sage employees will testify in court only in response to a subpoena. Such time is not reimbursable by Medicaid or other insurance and additional charges may accrue. Most CBRS specialists are not licensed professionals, and are unable to offer expert witness testimony. If they are called to testify in a custody dispute, child protection case, etc., they will describe what they have seen and heard (within the limits of the law), but will offer no opinions or interpretations. Most therapists are not qualified as "custody evaluators," and are ethically obligated to say as much if they are called upon to testify. Some therapists are qualified as "custody evaluators," but this service is not reimbursable by Medicaid or most insurance coverage. Additional charges WILL accrue for any such evaluation.

Health Insurance Portability and Accountability Act (HIPAA):

We utilize **Electronic technology** such as email, text, messenger, cell phones, etc. in all aspects of our practice, and the confidentiality of our members' PHI is our highest priority. Sending or receiving PHI through fax or an email included a Statement of privacy/confidentiality. In order to comply with HIPAA and other privacy laws and regulations, electronic platforms and services must have a plan to inform consumers in the event of a **data breach**. If we become aware of a data breach that may have compromised your information, we will promptly inform you. All paper **PHI records are Stored** in a locked cabinet, we maintain a password protected Electronic Health Record system to make every effort to avoid theft or violations of your privacy.

Third-Party: (Insurance) billing and communication, If utilizing third-party (insurance) coverage for services, we will be required to convey demographic and clinical information to the payer (e.g., insurance companies, Medicaid, Medicare). We utilize a Health Insurance Portability and Accountability Act "HIPAA compliant" online "electronic health record" system to maintain records and submit claims information. Some payers may require more detailed information regarding diagnosis, progress, and treatment goals. That information is submitted either via an online HIPAA compliant platform, fax, or as email attachments.

Email correspondence: Non-encrypted email is generally not considered to be a secure or private mode of communication. We make our email address known to members, and they may choose to correspond with us via email. They are informed of the risk that someone may be able to access their email. Limited email communications to scheduling and other non-therapeutic communication are recommended. Our emails include a "Confidentiality Notice;" however, there is no way to enforce those restrictions. We cannot guarantee that privacy will not be compromised when using email. If there are concerns about this, limit communication with meetings or the "land-line" office telephones.

Text message: Providers are discouraged from giving members their cell phone numbers. However, this is, at times, necessary. Like email, text messages are not considered to be secure. Office personnel may use outgoing text messages for the sole purpose of appointment reminders, but incoming text messages will not be acknowledged. Text messaging is not an acceptable or recommended way of communicating, canceling, or changing an appointment.

Social Media: Providers operate under various codes of ethics that provide guidelines on appropriate behavior. These do not prohibit providers from engaging with patients via social media but are strongly recommended against such practices. Our providers do not "friend" members or member's families on social media such as Facebook, Linked In, etc. This is to safeguard members' privacy and to maintain professional boundaries.

Online and Telehealth: Online/distance therapy calls for specialized training, the use of "HIPAA compliant" technology platform that provides for patient confidentiality and privacy. Except under particular circumstances, our therapists are not available for online therapy.

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NEW CLIENT INTAKE

Intake Cover Sheet

Clients Name: _____ Date: _____

- ❏ NEW CLIENT INTAKE PACKET
  - ❏ All pages and questions are completed with/by the Client and/or Guardian
  - ❏ Informed Consent Client Financial Responsibility Form is signed by the Client and/or Guardian
  - ❏ Copy turned in to be Uploaded into EHR
  - ❏ Copy given to Primary Therapist

- ❏ INSURANCE VERIFICATION COMPLETED
  - ❏ Copies of front and back of Insurance Cards uploaded into the EHR.
  - ❏ Eligibility confirmed
  - ❏ Prior Authorizations confirmed

- ❏ RELEASES OF INFORMATION

(must obtain appropriate consents to contact the member's behavioral health clinicians, medical physician, family/social supports, and/or agencies and other programs with which the member is or has recently been involved)

  - ❏ ROI's are completed for each individual / agency
  - ❏ ROI's are signed by the Member
  - ❏ ROI's turned in to be Uploaded into EHR or Faxed if needed

- ❏ COORDINATION OF CARE
  - ❏ ROI's sent to other providers
  - ❏ Requests for Records done
  - ❏ Copy of Medication list from Pharmacy received and uploaded into EHR

- ❏ MEDICAID ONLY (MEDICAID ADD ON PACKET)
  - ❏ All Pages Completed with/by the Client and/or Guardian
  - ❏ Copy turned in to be Uploaded into EHR
  - ❏ Copy given to Primary Therapist
  - ❏ History and Physical requested from PCP